

Reference Number: 200-09-DD

Title of Document: Fees for Residential Services Provided by the South Carolina Department of Disabilities and Special Needs (SCDDSN)

Date of Issue: December 1, 1990
Effective Date: December 1, 1990
Last Review Date: July 28, 2009 **REVISED**
Date of Last Revision: July 28, 2009

Applicability: Regional Centers and All Contracted Service Providers of Residential Services

I. PURPOSE

SCDDSN's authority for charging fees for its services was established by the SC Code of Laws [SC ST SEC 44-20-350], Medicaid regulations governing costs charged to Medicaid recipients and SCDDSN Commission policy. The purpose of this directive is to describe SCDDSN's policies and procedures for charging fees for residential services.

II. APPLICABILITY

This directive addresses only those fees charged for residential services provided to individuals residing in one of DDSN's Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) operated at DDSN's four regional centers and through community based facilities under contract with DDSN. Fees for services other than residential services are addressed in other departmental directives.

III. FEES

Residential services include room and board and all support services/programs provided as part of an ICF/MR program, except for certain medical services required for health reasons or for the medical determination of eligibility for an ICF/MR program.

The fee for residential services is a daily fee. The fee amount is based on the current per diem payment rate as approved in the Medicaid contract between SCDDSN and the South Carolina Department of Health and Human Services (SCDHHS). A listing of residential fees charged by DDSN may be found in Chapter 6 of the SCDDSN Finance Manual.

IV. PAYERS

Residential services should be billed in the following order:

- 1st – to trusts and third party insurance
- 2nd – to the individuals receiving the services (as they have resources to pay) and lastly,
- 3rd – to Medicaid (if the individual is Medicaid eligible.)

The determination of an individual's ability to pay is made according to Medicaid eligibility regulations as outlined in the SCDHHS Medicaid Program Manual. It is currently derived by calculating an individual's recurring income. This calculation is completed by an SCDDSN Sponsored SCDHHS Medicaid Eligibility Worker in accordance with an individual's application for Medicaid. The resulting calculation should be accepted by regional personnel without recalculation and used for billing purposes unless a specific exception is approved (see Section VII: OTHER MATTERS.)

V. MEDICAID ELIGIBLE BILLINGS

DHHS should be billed for each allowable day an individual is admitted to and resides in a DDSN regional center or community based habilitation facility under contract with DDSN. Unallowable days should not be billed. Allowable days (or approved leave) are defined in the Nursing Facility Services section of the Medicaid Provider Manual. Allowable days (approved leave) include the following:

- A hospital stay of up to 10 days:
An individual may be in the hospital 10 full days, returning to the facility on the 11th day.
- Up to 96 leave days per fiscal year:
Each individual residing in an ICF/MR facility is allowed up to a maximum of eight (8) days leave per month and two (2) separate sixteen day periods (consecutive days) of therapeutic leave if authorized by a physician. The total for the fiscal year may not exceed 96 days.
- A one-time 30 day consecutive leave per admission:
Each individual is allowed one 30-day consecutive leave per admission for discharge planning and permanent placement to a home environment. The attending physician must prescribe this leave as a vital part of the discharge planning activity. A leave of absence exceeding the allowable days requires a discharge from the facility.

VI. BILLING AGAINST ASSETS OF MEDICAID ELIGIBLE INDIVIDUALS WITH RECURRING INCOME

When an individual is Medicaid eligible and has resources sufficient to contribute to the cost of his/her residential services, the individual should be billed for each month of service. (See Section VII: OTHER MATTERS for an explanation of factors that may affect monthly billings.) The billing amount generally will not be adjusted on the basis of allowable days.

VII. MEDICAID INELIGIBLE BILLINGS

Individuals who are not Medicaid eligible should be billed at a fixed monthly rate based on the current Medicaid per diem rate. The fixed monthly rate should be adjusted whenever the current Medicaid per diem rate is adjusted. See Section VII: OTHER MATTERS for an explanation of factors that could affect monthly billings.

If an individual's assets are held by a parent, guardian or other responsible party, billings should be submitted to that party. If DDSN serves as trustee for an individual's funds, then billings should be submitted to DDSN and paid through the Regional Banking & Billing System.

If an individual has insurance that covers residential care, billings should be submitted to the insurance company. Billings to insurance companies should be for the maximum allowable payment up to the full cost of care.

VIII. OTHER MATTERS

A. Partial Month Billings

When an individual is admitted to or discharged from a DDSN regional center or community based facility under contract with DDSN, the billings addressed in Sections V, VI and VII should be adjusted to reflect a partial month. This partial month billing does not apply to allowable/approved leave situations as allowed by DHHS (see Section V: MEDICAID ELIGIBLE BILLINGS.)

B. Maximum Resources Level for Medicaid Eligibility

To prevent disruption of Medicaid eligibility, staff should monitor each individual's accumulation of resources to ensure that resources do not exceed the amount allowed under Medicaid eligibility guidelines. Regional claims and collections officers should contact an individual's program team if his or her resources approach the maximum level. The program team should first determine if the individual has personal needs, such as clothing. If needs exist, purchases should be made for that purpose ensuring that funds are expended on that individual's personal needs. If the available resources are still above or near the allowable level when the personal needs have been met, billing for residential services can be adjusted to the extent of any underbillings of full cost of care that have occurred in the past one year. Some situations that could create underbillings are credit days, granting fee waivers and the calculation of personal needs funds based on net rather than gross wages. If an individual still has excess resources after all personal needs have been exhausted and all prior underbillings have been paid, then he/she should become Medicaid ineligible for a period of time. During that period, full cost of care should be charged until the individual's resources are back to target asset level. (See Chapter 6 of the SCDDSN Finance Manual for target asset levels.) Actual billing amounts should be determined by the regional claims and collections officer based on expected future accumulations of resources beyond Medicaid allowable resource limits.

C. Personal Needs Allowance

Each individual, whether Medicaid eligible or not, should retain a portion of unearned income from Social Security, Supplemental Security Income or other income sources for their needs. This is called a "personal needs allowance". An individual's "personal needs allowance" should not be applied to payments of residential services or other departmental billings. Further information on the personal needs allowance may be found in Chapter 6 of the SCDDSN Finance Manual.

D. Consumers with Earned Income

Individuals who have earned income from work activities or other sources may retain that month's total income (from both earned and unearned sources) up to the earned income allowance level. Further information on earned income allowance may be found in Chapter 6 of the SCDDSN Finance Manual. An individual's earned monthly income should not be applied to payment of residential services or other departmental billings.

When calculating the funds to be retained by an individual, earned income after taxes and other withholdings should be used. (NOTE: This is different from the calculations done by DHHS.) This will result in smaller billings but it is consistent with the intention of this policy, which is to encourage each individual to experience monetary benefit from his or her work efforts. As a result of using net wages to determine the amount of funds to be retained, income tax returns should be filed for all individuals who have had income taxes withheld. The responsibility for completion of individual tax returns should be assigned by the facility directors. The refunded tax return amount, up to the difference in billings created by using net wages, should be billed to the individual after receiving the tax refund.

E. Application of Credit Days

A credit day is a residential service day for which an individual is liable for all or a portion of, but they were not charged that day's bill. Credit days are used to encourage or enable an individual to spend time away from the regional center or community habilitation facility. Generally, this means that funds which are made available through the reduction of a monthly billing should be used to cover the expenses incurred by the family while taking care of their family member for a short period of time.

A credit day is allowed when requested by the parent, guardian or other responsible party who will be taking the individual to their home and when it is determined by the regional claims and collections officer and the program team to be necessary. Both the request and determination made by the appropriate claims and collections officer should be documented and retained in the individual's file. All parents, guardians or other responsible parties should be informed at the time of admission of the availability of credit days and the procedure necessary to grant credit days.

When a credit day is allowed, the amount of the credit will be the pro-rata share of the residential service billing for that individual for that month. The full billing should be recorded on the Regional Banking and Billing System and the amount of the credit recorded through an adjustment.

F. Receipt of Social Security Back Payments

When an individual receives a Social Security back-payment, the funds should be used first to maximize the individual's personal needs allowance for the past 12 months. (See Attachment A: Maximizing of Personal Needs Allowance.) Secondly, if there is an outstanding care and maintenance balance, the back-payment should be applied to that. If after correcting personal needs allowances and paying back care and maintenance the entire payment is not used, the individual should keep the balance. If this balance gives the individual sufficient resources so that he/she becomes Medicaid ineligible, the resources should be used in accordance with Section VIII (B.) Maximum Resources Level for Medicaid Eligibility.

G. SCDDSN as Representative Payee

In cases where a parent, guardian or other responsible party is designated by the Social Security Administration (SSA) as representative payee for an individual who is in DDSN's residential care program, it is SCDDSN's policy *and* the intent of the SSA that the entire amount received be spent for the benefit of the individual. If a representative payee cannot demonstrate to the program team his or her proper use of these funds for the sole benefit of the individual, SCDDSN should petition SSA to become representative payee for the individual.

H. Waiver of Fees by District Director

Each district director has the authority to vary a residential service fee rate if there is a programmatic need for an individual to have additional funds associated with a planned relocation to another residential setting. If an adjustment of all or a portion of residential fees is required, a written request with justification should be forwarded by the program team through the regional claims and collection officer to the appropriate district director. The request to waive fees should be limited to a maximum period of six (6) months. Upon district director approval, the written request should be returned to the regional claims and collection officer, who should in turn forward a copy to the appropriate residential unit to be placed in the individual's permanent file. All approved requests to waive all or a portion of residential fees should be reviewed by the program team and the claims and collections officer every six (6) months to determine if continuation is necessary.

Deputy State Director, Administration
(Originator)

State Director
(Approved)

MAXIMIZATION OF PERSONAL NEEDS ALLOWANCE EXAMPLE

MONTH	TYPES OF INCOME THIS MONTH	MAXIMUM PERSONAL NEEDS ALLOWANCE	PERSONAL NEEDS ALLOWANCE RETAINED	DIFFERENCE
12	Unearned only	\$30	\$30	\$0
11	Unearned only	\$30	\$25	\$5
10	Earned and Unearned	\$100	\$43	\$57
09	Earned and unearned	\$100	\$58	\$42
08	Earned and unearned	\$100	\$100	\$0
07	Earned and unearned	\$100	\$100	\$0
06	Earned and unearned	\$100	\$98	\$2
05	Earned and unearned	\$100	\$100	\$0
04	Unearned	\$30	\$0	\$30
03	Unearned	\$30	\$0	\$30
02	Unearned	\$30	\$0	\$30
01	Unearned	\$30	\$30	\$0
Total				\$196


In this example, from the back-payment received, \$196 would be given to the individual to maximize his or her personal needs allowance.

(Note: Personal needs maximums effective 7/01/1990 used in this example.)

MEMORANDUM

August 5, 2009

TO: Official Distribution

FROM: Martin K. Taylor, CPA 
Director of Finance

RE: Revision of 200-09-DD

Departmental Directive 200-09-DD, *Fees for Residential Services Provided by the South Carolina Department of Disabilities and Special Needs*, has been updated to reflect current names, titles and terms.

The official review period for comments will end on 8/31/09. Please direct your comments, if any, to me by one of the means of communication listed below:

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Attachment